PERMISSION TO RELEASE MEDICAL RECORDS

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name: _____Date of Birth: ___/___/___

Permission is hereby granted for Release of Information

From: Name: _____
(Medical Provider Holding Records)

Address: _____

City: _____ State: _____Zip Code: _____

To: Name: _____

Address: _____

City: _____ State: _____Zip Code: _____

Phone #:_____Fax #:_____

Please mark what you are requesting: Chart Notes X-Rays (disc or printed)

The purpose for the release is _____
Transfer of care _____YES_____NO

The following date of service: From _____Through_____

This permission expires 6 months from the date signed or_____
Specified Expiration Date

Required _____ Initial
***I do ____do not_____ specifically consent to the transmission of my medical records via a fax machine.

Initial in the spaces provided:

- ____I recognize that the information disclosed may contain drug/alcohol information that is protected by federal and state law. I specifically consent to disclosure of such information.
- ____I recognize that the information disclosed may contain mental health information that is protected by federal and state law. I specifically consent to disclosure of such information.
- ____I recognize that the information may contain information regarding sexually transmitted diseases or HIV/AIDS testing information. I consent to the disclosure of such information.

_____ _____
Signature of Patient or Representative Relationship (if signed by representative)

_____ _____
Date Signed Witness (Optional)